

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 shall be kept until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BERNARD F. BOSSE</b>				Jan 14 1984 12:30 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 2, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Grain Elevator		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Anton B. Bosse		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Cotremba		13e. STREET ADDRESS 405 Light Street		21613	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-05-0630		17. INFORMANT Mary Benhoff		ADDRESS RD #2 Box 369 Hanover, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>4 days</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 days</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Heart Failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/2/84</u> , 19____, to <u>1/14/84</u> , 19____, that (I) (we) lost saw the deceased alive on <u>1/13/84</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lawrence Maryanov M.D.				DEGREE M.D.		22c. DATE SIGNED 1/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence Maryanov, M.D.				22e. ADDRESS 610 Race St Cambridge, MD 21613		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 17 1984		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 17 1984	
				25b. REGISTRAR'S SIGNATURE John J. Conner			



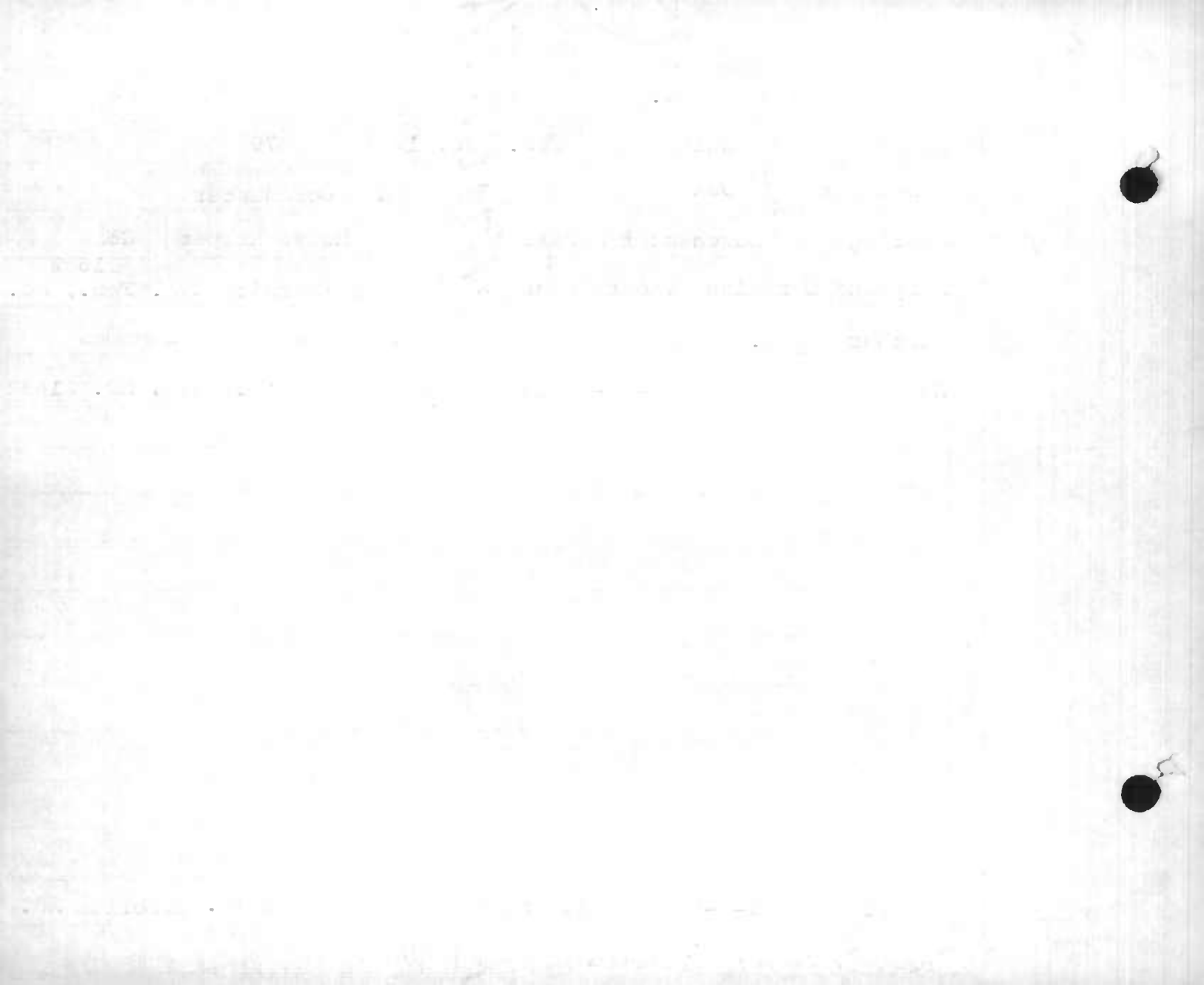
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Lydia L. Crew</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1 5 84</i>		2b. HOUR <i>8 p.m.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 26, 1904</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Delaware</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i> MD
10. CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester Memorial</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>House keeper</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>
13a. STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Caroline</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <i>University Ave. Fed., Md. 21632</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Arthur R. Beebe</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sarah Jane Sammons</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-22-8521A</i>		17. INFORMANT ADDRESS <i>Amos Beebe Federalsburg, Md. 21632</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>1830 IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>C of ovaries c metastasis</i> DUE TO, OR AS A CONSEQUENCE OF: (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>CVA possible due to metastasis, Dynamic B. Syndrome</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>E. Tanman</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>1-5-84</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Eyup Tanman</i>		22e. ADDRESS <i>17 Franklin St. Cambridge, MD 21613</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-8-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Federals. Caroline Md.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>James Miller Federalsburg, Md</i>				
25a. DATE REC'D. BY REGISTRAR <i>JAN 10 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John L. Conner</i>				

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 0 1 8 5 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Evangeline B. Crippen</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>1 7 84</i>		2b. HOUR <i>4:50 P.M.</i>	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>2 18 99</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>84</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Cambridge</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cambridge House</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>		13b. COUNTY <i>Dorchester</i>	13c. CITY OR TOWN <i>Cambridge</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <i>Thomas</i> MIDDLE <i>Bayard</i> LAST <i>Harper</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Gertrude</i> MIDDLE <i>Harper</i> LAST <i>Harper</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-74-0134</i>		17. INFORMANT P. ADDRESS <i>P.O. Box 338</i> <i>Robert Corkran Hurlock, MD 21643</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>4360</i> IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs. (1 day)</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i>		<i>4 yrs.</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>generalized Arteriosclerosis</i>		<i>10 yrs.</i>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1/7/84</i> 19 <i>1984</i> to <i>1/7/84</i> 19 <i>1984</i> , that (I) (we) lost saw the deceased alive on <i>1/6/84</i> 19 <i>1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Lawrence Maryann MD</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>1/7/84</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lawrence Maryann MD</i>		22e. ADDRESS <i>610 Race St Cambridge, MD 21613</i>	

23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>	23b. DATE <i>1-11-84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>EastNewMarket Cem.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>E. New Market Dor. MD</i>
24. FUNERAL DIRECTOR NAME <i>Zeller Funeral Home, EastNewMarket, MD</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 24 1984</i>	25b. REGISTRAR'S SIGNATURE <i>John G. Smith</i>

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Other General Notes, Eastwood Street, 1-11-12

1-11-12 Eastwood Street, New York, N.Y.

Dear Mr. Eastwood:

I have just received your letter of the 10th inst.

and am glad to hear that you are interested in the

subject of the "Eastwood" project.

I am sure that you will find the information

contained in the enclosed report of interest.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RAYMOND C DAYTON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 14 1984</b>		2b. HOUR <b>5:14 AM</b>
1. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>09 14 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester MD.</b>		
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>restaurateur</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Dorchester</b>	13c. CITY OR TOWN <b>Cambridge</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clarence Dayton</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Adams</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW 2 214-07-9853</b>		17. INFORMANT ADDRESS <b>James A. Dayton Rt 1 Box 153 Cambridge Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>5860</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acidosis + Electrolyte imbalance</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal Failure</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>DM x edema 2) Congestive Heart Failure 3) Massive Obesity</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1/12/84</b> to <b>1/14/84</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>1/13/84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>H. Noel Reynolds MD</b>				22c. DATE SIGNED <b>1/14/84</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. Noel Reynolds</b>				22f. ADDRESS <b>408 Bym St, Cambridge, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>1/17/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CAMBRIDGE DOR. MD.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>THOMAS FUNERAL HOME CAMBRIDGE MD.</b>				25a. DATE REGD. BY REGISTRAR <b>JAN 19 1984</b>		
25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>						





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IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 0 1 8 5 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS FRANK FRAZIER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 12 84</b>			2b. HOUR <b>8:20 P.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 10 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS <b>75</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		9. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b> MD.			
12. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>EASTERN SHORE HOSP. CTR</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer &amp; Carpenter</b>		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE <b>Hurlock MD.</b>		17b. CITY <b>TALBOT</b>		17c. CITY OR TOWN <b>EASTON</b>		18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. STREET ADDRESS <b>RT. 2 Box 708 EASTON MD.</b>	
20. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES FRAZIER</b>				21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMILY HOLIDAY</b>				22. ADDRESS <b>21655</b>	
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		24. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-32-2073</b>		25. INFORMANT <b>Lorraine Adams, P.O. Box 82, Preston, Md.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARD-VASC. DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>YEARS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72 HRS.</b>	
--	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6-23-81</b> P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (a) (this hospital) attended the deceased from <b>6-23-81</b> , 19 <b>84</b> , to <b>1-12</b> , 19 <b>84</b> , that (b) (we) lost <b>1-12</b> <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Donald F. Bartley M.D.</b>				DEGREE <b>MD.</b>		22c. DATE SIGNED <b>1-12-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD F. BARTLEY M.D.</b>				22e. ADDRESS <b>EASTERN SHORE HOSP. CTR.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 16, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hurlock, Dorchester, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Frampton-Hawkins Box 43 Federalville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1984</b>		25b. REGISTRAR'S SIGNATURE <b>See 2 C. 11</b>	

Burial Jan. 16, 1984 Washington Cemetery Hurlock, Dorchester, Maryland

Lorraine Adams, P.O. Box 82, Preston, Md.  
21655

Farmer & Carpenter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDWARD WILLIAM GREENSTREET, JR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 26, 1984</b>		2b. HOUR <b>8:26 PM</b>		
3. SEX <b>MALE</b>		4. RACE <b>CAU.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 15, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MAINE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b> MD.	
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DORCHESTER GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>builder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>DORCHESTER</b>		13c. CITY OR TOWN <b>CAMBRIDGE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD WILLIAM GREENSTREET</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HELEN ANNA EDLUND</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES WW II</b>		16b. SOCIAL SECURITY NO. <b>212-09-5231</b>	
17. INFORMANT <b>wife</b>		ADDRESS <b>same as 13c</b> <b>Mrs. Anna C. Lee Thumm Greenstreet</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Concertive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary artery disease, mitral insufficiency</b> Approximate interval between onset and death: <b>1 minute</b> <b>Several years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Rheumatoid arthritis, pneumonia, peripheral vascular disease, renal failure</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>Dec 6, 19 83</b> , to <b>Jan 26, 19 84</b> , that (1) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>E. MacLaughlin</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/26/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edmund John MacLaughlin</b>		22e. ADDRESS <b>10 Aurora St. Cambridge Md 21613</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 30, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cem. of E. Shore</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Beulah, Dorchester, Md.</b>	
24. FUNERAL DIRECTOR <b>CURRAN FUNERAL HOME, 308 High St., Cambridge, Md. 21613</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 31 1984</b>		25b. REGISTRAR'S SIGNATURE <b>C. Smith</b>	

BP



## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

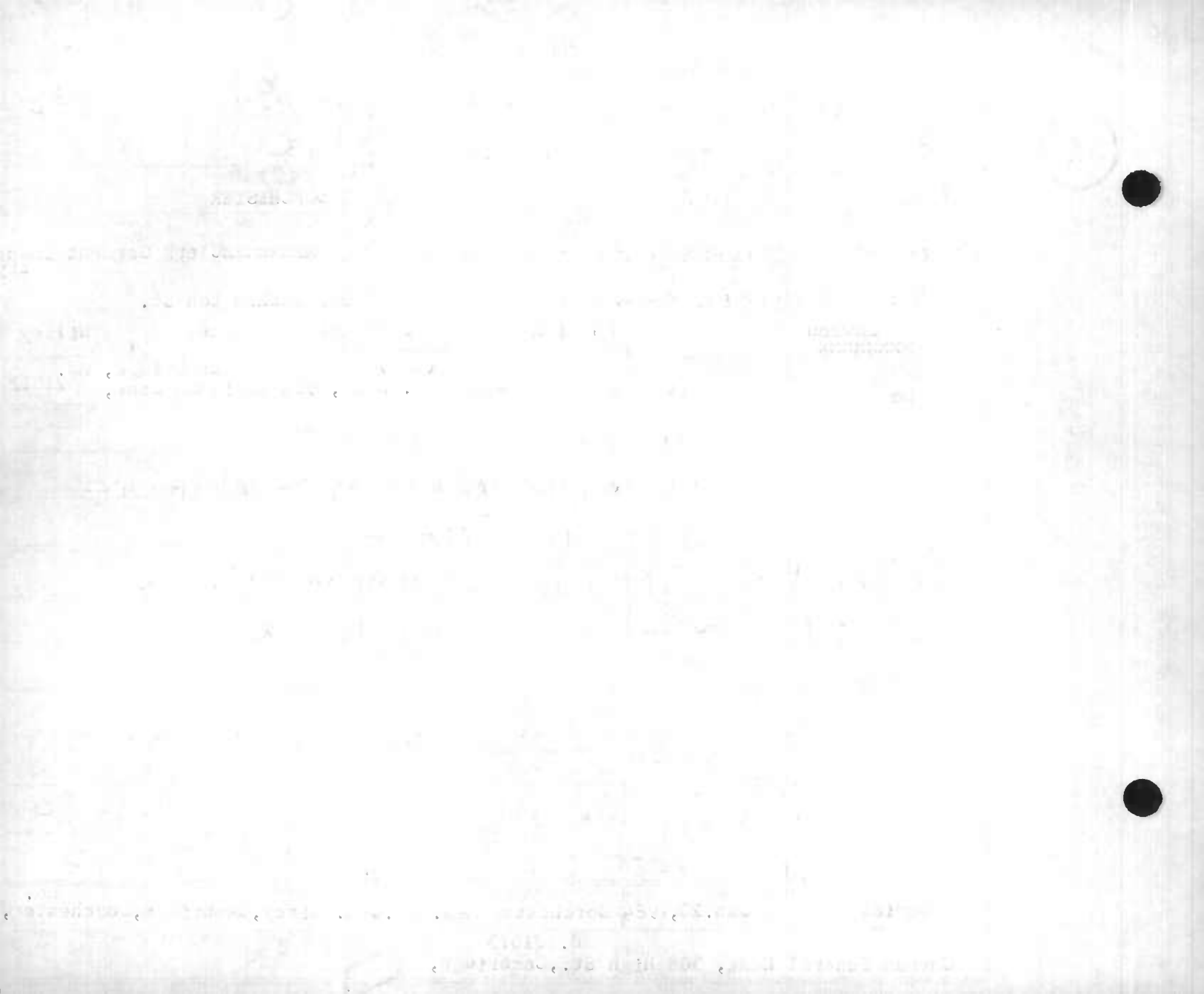
1 DECEASED NAME (TYPE OR PRINT) Dollye W. HALL			2a DATE OF DEATH MONTH DAY YEAR 1-17-84			2b HOUR 5:25 P.M.				
3 SEX F		4 RACE CAU		5 DATE OF BIRTH MONTH DAY YEAR 1 26 00		6 AGE (IN YEARS LAST BIRTHDAY) 83				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD				
10 CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSP				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) xxxxxx Clerk		12b KIND OF BUSINESS OR INDUSTRY Garment Industry		
13a STATE Md				13b COUNTY DORCHESTER		13c CITY OR TOWN CAMBRIDGE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Lawson				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Agnes Willey				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		
16b SOCIAL SECURITY NO. 084-14-9148				17 INFORMANT (son) Donald B. Hall, 904 Talisman Lane, 21613				ADDRESS Cambridge, Md 21613		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardio Respiratory Arrest 4471 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Electrolyte imbalance, Renal Failure (c) poor oral intake DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diffuse Venous Thrombosis, Unknown Etiology									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION 12/25/84			19b CONDITION FOR WHICH OPERATION WAS PERFORMED Arterial insufficiency			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 83, to 1/17 84, that (I) (we) lost saw the deceased alive on 1/17/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22b. SIGNATURE H. Noel Ken MD 22c. PHYSICIAN'S NAME (TYPE OR PRINT) 408 Bynn Street Cambridge Md 21613	
22d. DATE SIGNED 1/17/84			22e. ADDRESS 408 Bynn Street Cambridge Md 21613			22f. DATE SIGNED 1/17/84			22g. REGISTER'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 20, 1984		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Pk. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Airey, Cambridge, Dorchester, Md.		23e. DATE REC'D. BY REGISTRAR JAN 19 1984	
24 FUNERAL DIRECTOR NAME Curran Funeral Home, 308 High St., Cambridge,			ADDRESS Md. 21613		25a. DATE REC'D. BY REGISTRAR JAN 19 1984			25b. REGISTRAR'S SIGNATURE		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>REBA</b>		FIRST <b>I</b>	MIDDLE	LAST <b>HARRIS</b>	2a. DATE OF DEATH MONTH <b>1</b> DAY <b>14</b> YEAR <b>84</b>		2b. HOUR <b>12:36AM</b>	
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>07</b> DAY <b>04</b> YEAR <b>05</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester Co.</b> MD		
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <b>Md.</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>J. H.</b> MIDDLE <b>Grant</b> LAST <b>Bramble</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Lyda</b> MIDDLE <b>Pritchett</b> LAST <b>Pritchett</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				
16b. SOCIAL SECURITY NO. <b>214-07-8347</b>		17. INFORMANT ADDRESS <b>Rt 5 Box 177 Winifred Hobron Poplarville Miss.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> 4100								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>40 min</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								(b) <b>VENTRICULAR TACHYCARDIA</b> 40 min
(c) <b>MYOCARDIAL INFARCTION</b>								6 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>PM 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <b>1/14</b> 19 <b>84</b> to <b>1/14</b> 19 <b>84</b> , that (1) (we) last saw the deceased alive on <b>1/14</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Michael A. Moskewicz</b> MD				DEGREE <b>MD</b> ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/14/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL A. MOSKEWICZ MD</b>				22e. ADDRESS <b>503 BAYEN ST. CAMBRIDGE MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>1/16/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>E. NEW MARKET CEM.</b>		23d. LOCATION CITY OR TOWN <b>E. NEW MARKET</b> COUNTY <b>DOR.</b> STATE <b>MD.</b>		
24. FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME CAMBRIDGE MD.</b> ADDRESS				25a. DATE REGD. BY REGISTRAR <b>JAN 19 1984</b> REGISTRAR'S SIGNATURE <b>John J. Chief</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>David Hosea</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1-23 1984</b>			2b. HOUR <b>P.M.</b>		
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 14, 1964</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>64</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>Jan. 23, 1984</b>	2d. HOUR <b>12:44</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>?</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester County</b>		
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>906 Phillips St</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>			13b. COUNTY <b>Dor.</b>	13c. CITY OR TOWN <b>Cambridge</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>906 Phillips St. 21613</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No.</b>			16b. SOCIAL SECURITY NO. <b>255-14-7383</b>		17. INFORMANT ADDRESS <b>Maud Hosea Cambridge, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few Mins.</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Mace Jr.</i>			TITLE (SPECIFY) <b>Deputy</b>			DATE SIGNED <b>1/25/84</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John Mace Jr. M.D.</b>			ADDRESS <b>Cambridge, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/28/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge, Dor. Md</b>		
24. FUNERAL DIRECTOR NAME <b>St. Clair Funeral Home</b>			ADDRESS <b>Cambridge, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>1/28/84</b>		

1586-58 NVC



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 0 1 8 6 2

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>NANCY</b>	MIDDLE <b>L.</b>	LAST <b>JONES</b>	2a. DATE OF DEATH		MONTH <b>1</b>	DAY <b>17</b>	YEAR <b>84</b>	2b. HOUR <b>2:27</b>	AM <input checked="" type="checkbox"/>	PM <input type="checkbox"/>
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		32				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.						
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>teller, bank</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Md.</b>		13b. COUNTY <b>Dor.</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt 1 Box 536</b>		21613		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
FIRST <b>Robert</b>		MIDDLE <b>Emmett</b>		LAST <b>Dewlin</b>		FIRST <b>Ruth</b>		MIDDLE <b>Seward</b>		LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>216-56-1231</b>		17. INFORMANT <b>Randy Jones</b>		ADDRESS <b>Item #13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> <b>2894</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hepatic Coma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>End stage Hepatic Cirrhosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Splenomegaly, Thrombocytopenia, Coagulopathy</b>												
19a. DATE OF OPERATION <b>1/10/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hypersplenism</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 1983</b> 19____, to <b>JAN 17</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>1/17/84</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>H. Neal Reynolds</b>		22c. DATE SIGNED <b>1/17/84</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. Neal Reynolds</b>		22f. ADDRESS <b>408 Byrn St, Cambridge</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>1/19/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEM. PARK CAMBRIDGE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>DOR. MD.</b>						
24. FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME</b>		ADDRESS <b>CAMBRIDGE MD,</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1984</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>								

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

11668



*[Faint, mostly illegible handwritten text on lined paper. The text appears to be a list or series of entries, possibly related to a collection or inventory. Some words like "Box" and "No." are faintly visible.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 0 1 8 6 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Adele L Lewis</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>1-03-84</i>		2b. HOUR <i>1:15</i> M
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11 23 02</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. CITY OR TOWN OF DEATH <i>Cambridge</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cambridge House</i>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i> MD		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <i>Md.</i>		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>homemaker</i>		12c. KIND OF BUSINESS OR INDUSTRY
13a. COUNTY <i>Dorchester</i>	13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13c. STREET ADDRESS <i>Taylor's Is</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Lewis Jenkins Horseman</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lula Adele Brumbley</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-50-6008</i>		17. INFORMANT ADDRESS <i>Box 11 Church Creek</i>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY ARREST</i> <i>1830</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>METASTATIC CARCINOMA OF OVARY</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CARCINOMA OF OVARY</i>		APPROXIMATE INTERVAL BETWEEN ONSET OF DEATH <i>minutes</i> <i>months</i> <i>months</i>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *none*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>1981</i> <i>12/23</i> P.M. <i>83</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <i>13</i> <i>84</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>1981</i> to <i>1/3</i> 19 <i>84</i> , that (I) (we) lost <i>1/3</i> saw the deceased alive on <i>12/23</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>David B. Stoeckle</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>1/3/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAVID B. STOECKLE M.D.</i>		22e. ADDRESS <i>400 AURORA ST. CAMBRIDGE, MD 21613</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>	23b. DATE <i>1/5/84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Dorchester Mem. Pk.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cambridge Dor. Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Thorn Funeral Home</i>		ADDRESS <i>700 Front St Cambridge, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 09 1984</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

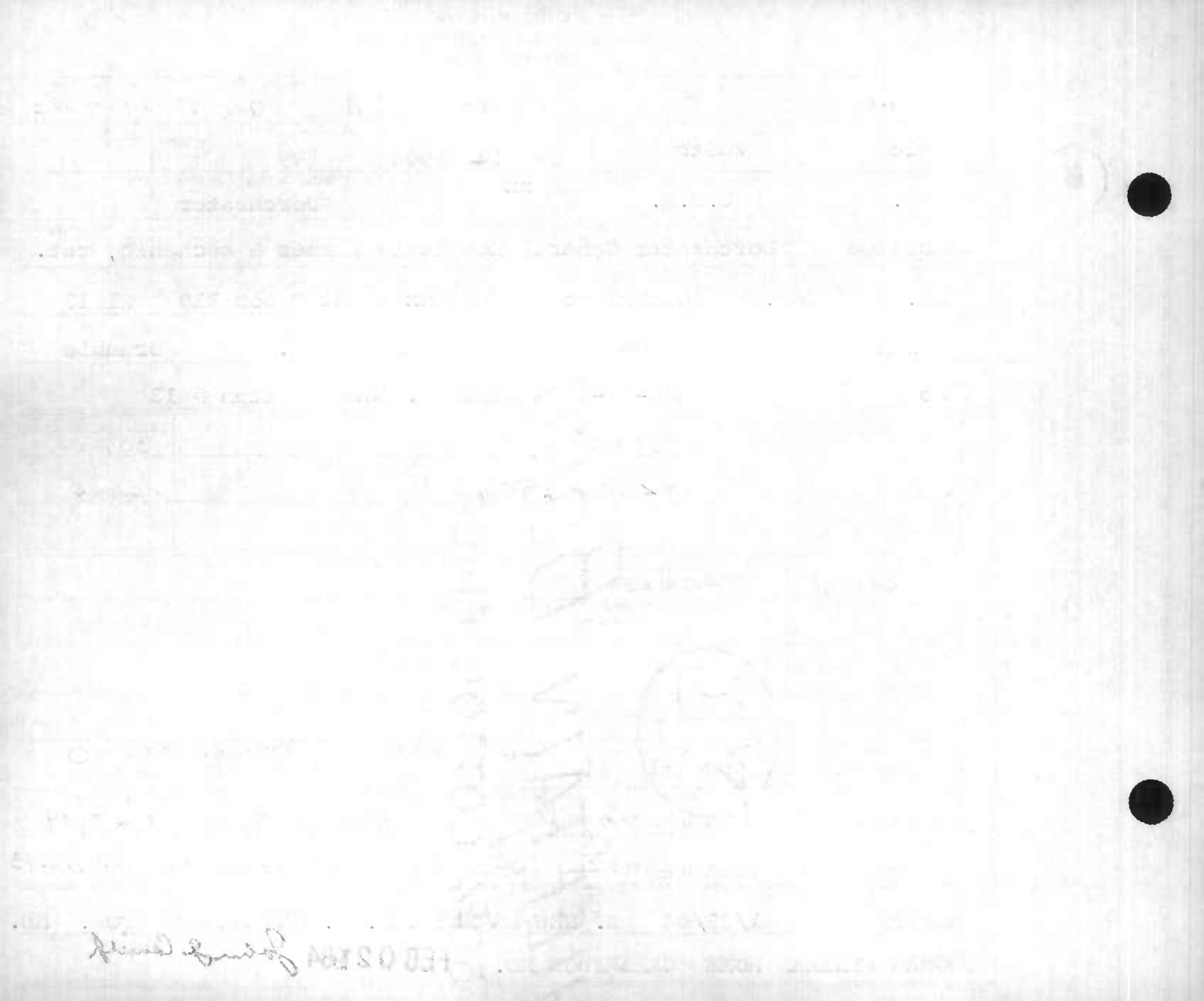
8 4 0 1 8 6 4

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>RAYMOND F HOWE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 27 84</b>		2b. HOUR <b>7 57 AM</b>
3 SEX <b>male</b>	4 RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>04 14 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.		
10. CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer &amp; mechanic, ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>			13b. COUNTY <b>Dor.</b>	13c. CITY OR TOWN <b>Cambridge</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Lowe</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Beulah E. Bramble</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-42-9861</b>	17. INFORMANT ADDRESS <b>Ethel H. Lowe Item # 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STROKE</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>RENAL FAILURE</b>					
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <b>Sept 19 77</b> , to <b>JAN 27 19 84</b> , that (1) (we) lost saw the deceased alive on <b>JAN 27 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Michael A. Moskiewicz</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/27/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL A. MOSKIEWICZ</b>		22e. ADDRESS <b>503 BARN ST. CAMBRIDGE MD 21613</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b. DATE <b>1/29/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>E. NEW MARKET CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>E. NEW MARKET DOR. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME</b>		ADDRESS <b>CAMBRIDGE MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 02 1984</b>	

MEDICAL CERTIFICATION

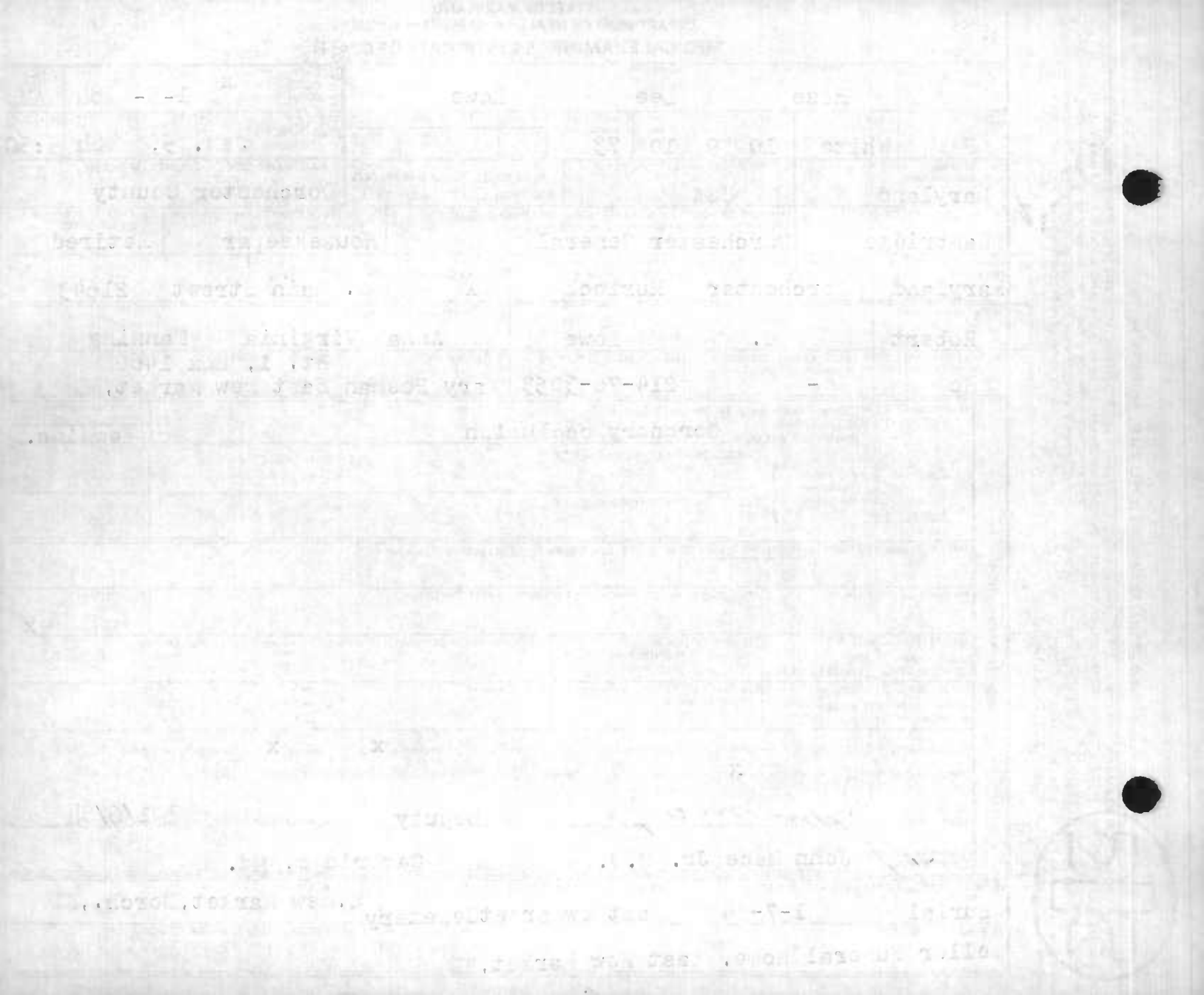




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose Lee Lowe										2a. DATE KNOWN OF DEATH ESTI-MATED MONTH DAY YEAR 1-5-1984										2b. HOUR AM-PM AM				
3. SEX F		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 9 10		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 73		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Jan. 5, 1984										2d. HOUR 5:50				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County				AM								
10. CITY OR TOWN OF DEATH Cambridge				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper				12b. KIND OF BUSINESS OR INDUSTRY Retired				MD								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland										13b. COUNTY Dorchester		13c. CITY OR TOWN Hurlock		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS S. Main Street 21643								
14. FATHER'S NAME FIRST MIDDLE LAST Robert G. Lowe					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Virginia Manning																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 214-76-3053					17. INFORMANT Rt. 1, Box 146D Mary Bosman East New Market, MD														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Mins.														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																								
ACTUAL SIGNATURE John Mace Jr.					TITLE (SPECIFY) M.D. Deputy					MEDICAL EXAMINER					DATE SIGNED 1/6/84									
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.					ADDRESS Cambridge, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 1-7-84					23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery					23d. LOCATION CITY OR TOWN COUNTY STATE East New Market, Dorch., MD									
24. FUNERAL DIRECTOR NAME Zeller Funeral Home										ADDRESS East New Market, MD					25a. DATE REC'D. BY REGISTRAR JAN 13 1984					25b. REGISTRAR'S SIGNATURE John J. Corbett				

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMH-17-20M 1/73  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Melissa J. Magnuson</b>										20. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 19 <input type="checkbox"/> 1984 4:54A	
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>14</b> YEAR <b>58</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>25</b> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	7c. DATE PRONOUNCED DEAD MONTH <b>1</b> DAY <b>19</b> YEAR <b>1984</b>		7d. HOUR <b>4:54A</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.J.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b>		MD.			
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>New Jersey</b>		13b. COUNTY <b>Gloucester</b>		13c. CITY OR TOWN <b>Franklinville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Blackwoodtown Road</b>			
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>J.</b> LAST <b>Magnuson</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Alice</b> MIDDLE <b>Paves</b> LAST <b>Paves</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>152-56-4196</b>		17. INFORMANT <b>Charles J. Magnuson</b>		ADDRESS <b>Item #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries, severe</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>8199</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION <b>1/19/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Abdominal trauma</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2:30A 1 19 1984</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Auto Accident</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>E. Harrington Bridge</b>		21f. LOCATION STREET <b>Cambridge</b>		CITY OR TOWN <b>Dorchester</b>		COUNTY <b>Md.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John Mace</i>		TITLE (SPECIFY) M.D. <b>DEPUTY</b>				MEDICAL EXAMINER		DATE SIGNED <b>1/19/84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. John Mace</b>		ADDRESS <b>Cambridge, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>1/23/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Green Cem.</b>		23d. LOCATION CITY OR TOWN <b>Clayton Gloucester N.J.</b>					
24. FUNERAL DIRECTOR NAME <b>BARCLAY FUNERAL HOME CLAYTON N.J.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical officer must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Anna Mae Murphy</u>			2a. DATE OF DEATH MONTH <u>1</u> DAY <u>14</u> YEAR <u>84</u>		2b. HOUR <u>11:50 P.M.</u>
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>10</u> DAY <u>7</u> YEAR <u>00</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester County</u> MD.		
10. CITY OR TOWN OF DEATH <u>Cambridge</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Cambridge House</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>-</u>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <u>MD</u>	13b. COUNTY <u>Dorchester</u>	13c. CITY OR TOWN <u>E. New Market</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <u>MD Route 14 21631</u>	
14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>W.</u> LAST <u>Dunn</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Margaret</u> MIDDLE <u></u> LAST <u>Parrot</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>215-38-1062</u>		17. INFORMANT <u>Rt. address, Box 167</u> <u>Alice Wilson Rhodesdale, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>YEARS</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>					
19a. DATE OF OPERATION <u></u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u></u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u></u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u></u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u></u> <u></u> <u></u> <u></u>	
22a. I certify that (1) (this hospital) attended the deceased from <u>11/23, 1982</u> , to <u>1/14, 1984</u> , that (1) (we) last saw the deceased alive on <u>1/14, 1984</u> , and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Michael A. Moskewicz</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>1/14/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MICHAEL A. MOSKEWICZ MD</u>		22e. ADDRESS <u>503 BYEN ST. CAMBRIDGE MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>1-17-84</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EastNewMarketCem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>EastNewMarket, Dorch., MD</u>	
24. FUNERAL DIRECTOR <u>Zeller Funeral Home, East New Market, MD</u>		25a. DATE REC'D. BY REGISTRAR <u>JAN 25 1984</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, a report of injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Pearl B Nagel</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1/5/84</i>				2b. HOUR <i>6 P M</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>September 1, 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i>		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Hurlock, Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester MD.</i>					
10. CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cambridge House</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Telephone Operator Telephone Co.</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Dorchester</i>		13c. CITY OR TOWN <i>Cambridge</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>520 Glenburn Avenue 21613</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>John W. Windsor</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Alice Harding</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				16b. SOCIAL SECURITY NO. <i>212-03-6636A</i>		17. INFORMANT ADDRESS <i>Florida 32757</i> <i>Eunice W. Harris, 704 Summit St., Mt. Dora,</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>2500 Cardio-Respiratory Arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) <i>ASCVD</i>	
										(c) <i>Diabetes Mellitus</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <i>Urinary Tr. Infection</i>											
19a. DATE OF OPERATION <i>1-5-84</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>E. Tanman</i>								DEGREE <i>MD</i>		22c. DATE SIGNED <i>1-5-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. Tanman</i>								22e. ADDRESS <i>17 Franklin St. Cambridge MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Jan. 7, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Unity Washington Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hurlock, Dochester, Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Frankton-Hawkins T.H.</i>				ADDRESS <i>Box 43 FEDERALSBURG</i>		25a. DATE REC'D BY REGISTRAR <i>JAN 10 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Gough</i>			

BP



Serial Jan. 7, 1934 Unity Washington Gen. Burlock, Dorchester, Maryland

212-03-6630A Eunice W. Harris, 704 Summit St., Mt. Dora, Florida 32757  
 John W. Windsor  
 Alice Harding

Maryland Dorchester Cambridge X 520 Glendon Avenue

Cambridge House

Telephone Operator Telephone Co.

Burlock, Maryland U.S.A.

X Dorchester

Female white September 1, 1901 82





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John L Neighbors			2a. DATE OF DEATH MONTH DAY YEAR 1 5 84			2b. HOUR M M			
3. SEX M		4. RACE cauc		5. DATE OF BIRTH MONTH DAY YEAR 8 2 4		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) XXXXXX Machinist		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Robert Kent Neighbors			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Rose Harkrader			13e. STREET ADDRESS / ZIP CODE 103 C hoptank Ave. 21613			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 185-10-3285		17. INFORMANT Miss Linda Neighbors		ADDRESS 103 Choptank Ave. Cambridge, Md. 21613			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 CARDIAC ARRYTHMIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES HOURS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/5/84 to 1/5/84, that (we) lost saw the deceased alive on 1/5/84, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David B. Stoeckle MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID B. STOECKLE MD			22e. ADDRESS 400 AURORA ST. CAMBRIDGE, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-8-84		23c. NAME OF CEMETERY OR CREMATORY Dorchester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dorchester, Md.		
24. FUNERAL DIRECTOR NAME Curran Funeral Home			ADDRESS 308 High St. Cambridge, Md. 21613			25a. DATE REC'D. BY REGISTRAR JAN 12 1984			
25b. REGISTRAR'S SIGNATURE John A. Smith									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Robert E. Perkins</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-5-84</b>		2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 4 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Colorado</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cambridge House Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Intelligence</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>	13c. CITY OR TOWN <b>Rhodesdale</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>Rt. 1, Box 183</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Perkins</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>unknown</b>		16b. SOCIAL SECURITY NO. <b>219-05-7989</b>		17. INFORMANT ADDRESS <b>Cambridge, Pauline R. Short, Cambridge House, Md. 21613</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4292 IMMEDIATE CAUSE (a) Cardiovascular Collapse</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Organic Brain Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Cardiovascular Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <b>12-22-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Michael Fadden</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael Fadden, M.D.</b>		22e. ADDRESS <b>Hurlock, Maryland 21643</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 10, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park Falls Church, Virginia</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR BY REGISTRAR'S SIGNATURE <b>JAN 12 1984</b>			
24. FUNERAL DIRECTOR NAME <b>Frampton-Hawkins Funeral Home, 216 N. Main St.</b>		ADDRESS <b>Federalburg, Md.</b>		25. DATE REC'D. BY REGISTRAR BY REGISTRAR'S SIGNATURE <b>JAN 12 1984</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21b shows any injury, or other traumatic event, the medical examiner must be notified.

BP

Prampton-Hawkins Funeral Home, 216 N. Main St.  
 Federalburg, Md.  
 Jan. 10, 1904 National Memorial Park Falls Church, Virginia

Michael Fadden, M.D. Hurlock, Maryland 21643

unknown

219-05-2889

Pauline R. Short, Cambridge House, Md. 21613  
 Cambridge,

Edward Perkins

unknown

Maryland Dorchester Rhodebale

X Rt. 1, Box 183

Intelligence U.S. Govt.

Colorado U.S.A. Dorchester

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 01871

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS HILTON HOWARD PINKETT			2a. DATE OF DEATH MONTH DAY YEAR 1 16 84			2b. HOUR 3:30 M		
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 6 24 23		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.		
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer		12b. KIND OF BUSINESS OR INDUSTRY CANNERY
13a. STATE MARYLAND			13b. COUNTY DORCHESTER		13c. CITY OR TOWN VIENNA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE ROUTE #1, BOX 4/ 21869								
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM PINKETT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN SMITH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 215-18-4852		17. INFORMANT ADDRESS MARTHA B. PINKETT same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary embolism</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause: lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 15 da
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Coronary failure</u> 2 wks								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-15-84 to 1-16-84, that (I) (we) lost saw the deceased alive on 1-15-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Dr. Wilke</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-16-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR WILKE			22e. ADDRESS Fox Maryland Ave 21613					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/21/84		23c. NAME OF CEMETERY OR CREMATORY SALEM U.M. CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SALEM DORCHESTER MD.	
24. FUNERAL DIRECTOR JOLLEY MEMORIAL CHAPEL			Rt. #2, Jersey Road SALISBURY, MD.			25a. DATE REC'D. BY REGISTRAR JAN 27 1984		
			25b. REGISTRAR'S SIGNATURE <u>San J. C. Grier</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 01872

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Alton T. Pritchett</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>4</b> YEAR <b>84</b>		2b. HOUR <b>3:32 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>12</b> YEAR <b>12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b> <b>XXXXXXXXXX</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> <b>XXXXXXXXXX</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PACKING CO.</b>
13a. STATE <b>Md.</b>	13b. COUNTY <b>Dorch.</b>	13c. CITY OR TOWN <b>Wingate</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Po Box 59 21675</b>	
14. FATHER'S NAME <b>FRANKLIN E.A.</b> MIDDLE <b>PRITCHETT</b> <b>XXXXXXXXXX</b>			15. MOTHER'S MAIDEN NAME FIRST <b>HATTIE</b> MIDDLE <b>XXXXXXXXXX</b> LAST <b>ALICE SLACUM</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO XXXXXXXX</b>		16b. SOCIAL SECURITY NO. <b>213 - 12 - 5240</b>		17. INFORMANT ADDRESS <b>MRS. MARY POWLEY WINGATE, MD. 21675</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic squamous cell carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>November</b> 19 <b>83</b> , to <b>1/4</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>Dec.</b> 19 <b>84</b> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>E. MacLaughlin</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/4/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edmund J. MacLaughlin</b>		22e. ADDRESS <b>10 Aurora St. Cambridge Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>01-07-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEM. PK. CEM.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>CAMBRIDGE DORCHESTER MD</b>					
24. FUNERAL DIRECTOR NAME <b>CURRAN FUNERAL HOME</b>		ADDRESS <b>308 HIGH ST., 21613</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal investigator must be notified at once.

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U. C. L.      U. C. L.      *U. C. L.      U. C. L.*      U. C. L.      U. C. L.

DATE: 10/10/1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Louise Rieck</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 3, 1984</b>			2b. HOUR <b>5:30 Ma</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>06 21 1893</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Dor.</b> 13c. CITY OR TOWN <b>Wollford</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt 1 Box 75 21677</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Vonesh</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna unk.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>					16b. SOCIAL SECURITY NO. <b>214-74-6873</b>		17. INFORMANT ADDRESS <b>Louise Willey Item # 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Nephrosclerosis with chronic renal failure</b> <b>4039</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Heart Disease with heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>generalized Arteriosclerosis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b> <b>3 yrs</b> <b>20 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lawrence Maryanov MD</b>					DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/3/84</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lawrence Maryanov MD</b>					22e. ADDRESS <b>600 Racer St Cambridge, MA 021613</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>			23b. DATE <b>1/4/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Delmarva Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lewes Sussex Del.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>THOMAS FUNERAL HOME CAMBRIDGE MA.</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 09 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
1. FOR STATE REGISTRAR		REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Columbus						Statter		01-31-84								10 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
MALE		BLACK		AUG. 15, 1871		112		MONTHS		DAYS		HOURS		MIN.			
7b. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
MARYLAND		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		DORCHESTER										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Cambridge		CAMBRIDGE HOUSE		LABORER		RET.											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MD.		DOR		CAMBRIDGE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		520 GLENBURN AVE.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
JOHN		STATTER		N/A													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		216-54-9782		CAMBRIDGE HOUSE MRS. REC'S		520 GLENBURN AVE										CAMP. MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		C. H. Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4140		DUE TO, OR AS A CONSEQUENCE OF		Pulmonary Infection													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Generalized arteriosclerosis													
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a		Coronary Heart Disease		ASCVD													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>																	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED											
EYUP TANMAN		MD				1-31-84											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
EYUP TANMAN, M.D.		17 FRANKLIN ST. CAMBRIDGE, MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
BURIAL		02/04/84		WAGH		Cambridge		DOR.		MD.							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Julius C. Davis		FEB 09 1984		John J. Carter													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. This permit must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows a traumatic injury, or other traumatic event, a medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>GEORGE CHARLTON THOMAS</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>01 19 84</i>		2b. HOUR <i>10:30am</i>	
3. SEX <i>M</i>	4. RACE <i>CAU</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>02 16 05</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>DOR. Co. MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cambridge</i> MD.		10. BALTIMORE CITY OR COUNTY OF DEATH <i>Cambridge</i> MD.				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>DORCHESTER GENERAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>waterman</i>		
13a. USUAL RESIDENCE 13a. STATE <i>MD</i>		13b. COUNTY <i>DORCHESTER</i>		13c. CITY OR TOWN <i>FISHING CREEK</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>GEORGE W. THOMAS</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ALBERTA E. SCOTT</i>		16. SOCIAL SECURITY NO. <i>218-14-1954</i>		
17. INFORMANT ADDRESS <i>Box 80 Fishing Creek Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>AS A SECONDARY</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Several yrs.</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, HOW BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHERE <input type="checkbox"/> HOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>W. S. Sharpe</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M. S. SHARPE</i>		22e. ADDRESS <i>105 AURORA ST CAMBRIDGE</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/21/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>DORCHESTER MEM PK</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>CAMBRIDGE DOR MD.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>THOMAS FUNERAL HOME CAMBRIDGE MD.</i>				
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>JAN 31 1984 [Signature]</i>				

BP

1. *John G. Smith* 1884

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND (21201) PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Joy		MIDDLE Lynn		LAST Tilman		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 1-19-		DAY 19		YEAR 84		2b. HOUR AM	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 03 03 1964		6. AGE (IN YEARS) LAST BIRTHDAY 19 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR Jan. 19, 19 84		2d. HOUR 4AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.											
10. CITY OR TOWN OF DEATH Cambridge				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Emerson C. Harrington Bridge				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) assembler				12b. KIND OF BUSINESS OR INDUSTRY mfg.					
13a. STATE Md.				13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 915 Talisman Lane 21613							
14. FATHER'S NAME FIRST MIDDLE LAST Henry Elsworth Tilman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Magnuson													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 220-80-9289		17. INFORMANT Elsie M. Tilman				ADDRESS Item #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries, severe</u> 8121 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Mins.																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2AM 1-19-84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger in car which colided with another car.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Bridge on Rt. 50				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Near Cambridge, Dor., Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE John Mace Jr.				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 1/20/84					
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.				ADDRESS Cambridge, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/21/84		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Beulah Dor. Md.							
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME										ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR JAN 26 1984		25b. REGISTRAR'S SIGNATURE John J. Gush			



Printed by the  
OFFICE OF THE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BRADY P. TODD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 5 1984</b>		2b. HOUR <b>7:40</b> AM				
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 04 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD			
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester Gen. Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>seafood packer, self emp.</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>		13b. COUNTY <b>Dor.</b>		13c. CITY OR TOWN <b>Crocheron</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>21627</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard S. Todd</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Bramble</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-90-5987</b>		17. INFORMANT ADDRESS <b>Blanche L. Todd Item #13</b>					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous cell carcinoma of</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>left lung with metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 years</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION <b>Mar 83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>above</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>Dec 83</b> , 19 <b>83</b> , to <b>JAN 5</b> , 19 <b>84</b> , that (1) <del>was</del> lost saw the deceased alive on <b>JAN 4</b> , 19 <b>84</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>was</del> (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lewis M. Burdette</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Jan 5, 84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lewis M. Burdette</b>				22e. ADDRESS <b>4 Aurora St Cambridge Md 21613</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>1/9/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dor. Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dor. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME</b>				ADDRESS <b>CAMBRIDGE MD.</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP

10/10/1911

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BP

DHMH - 17  
(V R 15 ME (J))  
15M 7/77

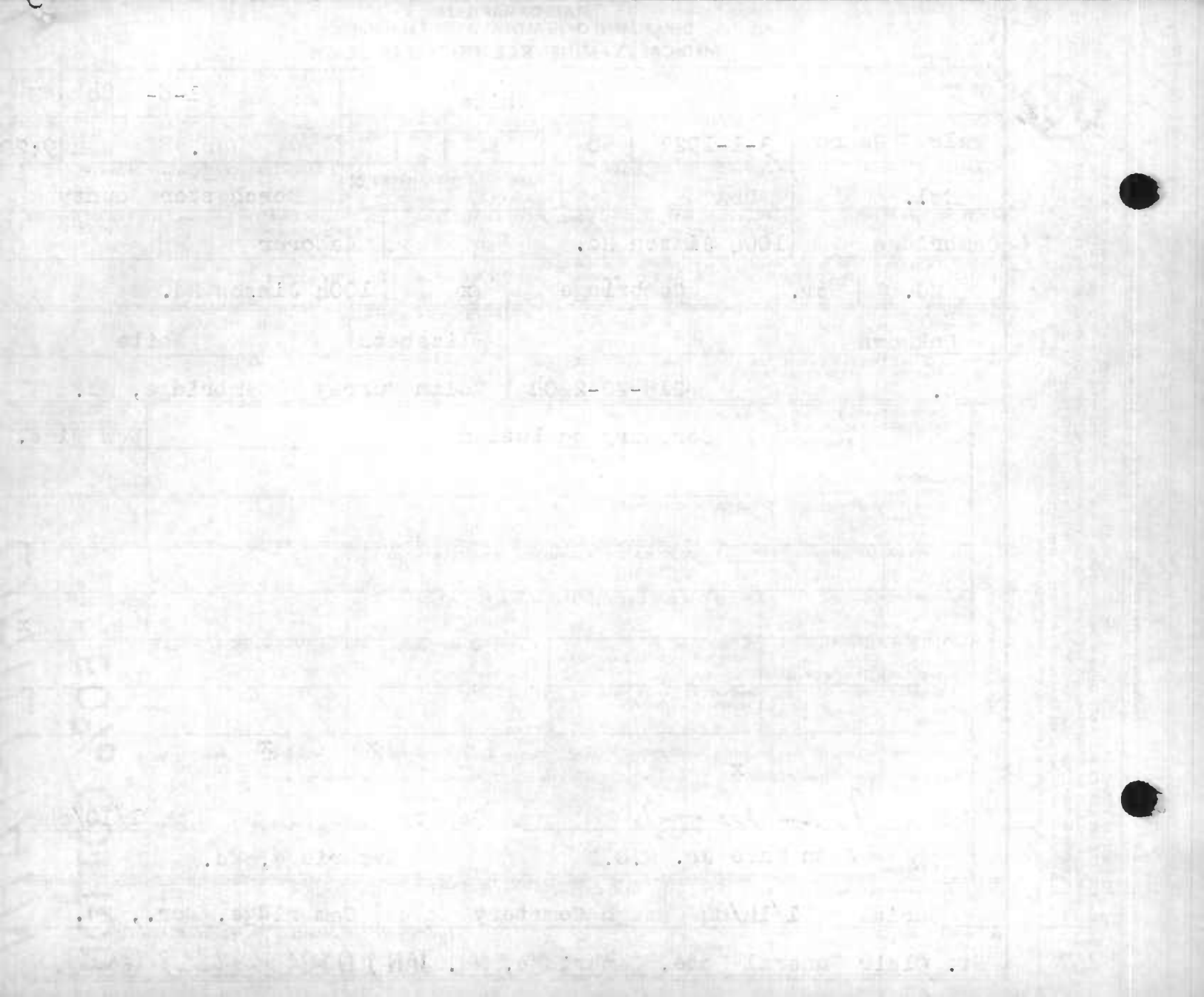
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>William White</b>			2b. DATE KNOWN OF DEATH MONTH DAY YEAR <b>1-8-84</b>			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Jan. 8 1984</b>			2d. HOUR AM PM <b>AM</b>					
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-1-1927</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>56</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Del.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester County</b>					
10. CITY OR TOWN OF DEATH <b>Cambridge</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1004 Jimson Rd.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Dor.</b>			13c. CITY OR TOWN <b>Cambridge</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>1004 Jimson Rd. 21613</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth White</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No.</b>				16b. SOCIAL SECURITY NO. <b>215-20-2204</b>				17. INFORMANT ADDRESS <b>Edith Murray Cambridge, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) Coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few Mins.</b>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <b>John Mace Jr.</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>1/10/84</b>						
EXAMINER'S NAME (TYPE OR PRINT) <b>John Mace Jr. M.D.</b>				ADDRESS <b>Cambridge, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/14/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Waugh Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge, Dor., Md.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>St. Clair Funeral Home, Cambridge, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 4 0 1 8 7 9			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
NORMAN WONGUS				1/26/84				10:15 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		BLACK		OCT. 12, 1911		72 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		USA				DORCHESTER MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
CAMBRIDGE		DORCHESTER GENERAL				LABORER		RET.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MD.		DOR.		CAMBRIDGE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		707 WRIGHT STREET 21613			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
JAKE L. WONGUS				ELLEN WONGUS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				218-14-4435		NORMA JEAN PRICE		433 NORTH ST SEAFORD, DEL.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Poss Pulm Embolus.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2520											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypercalcemia - Hyperparathyroidism</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHF.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
none								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/19, 1984</u> to <u>1/26, 1984</u> , that (I) (we) last saw the deceased alive on <u>1/26, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>Vinodrai Mehta</u>								1/26/84.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
VINODRAI MEHTA.				400 AURORA ST. CAMBRIDGE MD 21613							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
BURIAL		01-30-84		MT. PLEASANT		SALEM		DOR. MD.			
24. FUNERAL DIRECTOR				25. DATE RECD. BY REGISTRAR				26. REGISTRAR'S SIGNATURE			
FREDERICK C. DELANEY				FEB 9 1984				John J. Conner			

1454

1851

Hand Book

1880-81



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6401880

REG. NO

1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
JUDY E WRIGHTSON		01 26 84		8 45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH	
female		white		04 11 1924	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
W. Va.		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) dietary dept., hospital	
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge	
14. FATHER'S NAME Amos		15. MOTHER'S MAIDEN NAME Chlora E. Morris		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 235-34-4328		17. INFORMANT Joshua A. Wrightson Jr.		18. ITEM # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA</u> 1830 DUE TO, OR AS A CONSEQUENCE OF (b) <u>GENERALIZED METASTATIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF LEFT OVARY</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 MONTHS 9 MONTHS 9 MONTHS +			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION 4-7-83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION & TO METASTATIC CARCINOMA, LEFT OVARY		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from 4-7, 19 83, to 1-26, 19 84, that (b) (we) lost saw the deceased alive on 1-26, 19 84, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) did (did not) view the body after death.					
22b. SIGNATURE James F. McArthur, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-26-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES F. McARTHUR, M.D.		22e. ADDRESS 400 AURORA STREET CAMBRIDGE, MD., 21613			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/28		23c. NAME OF CEMETERY OR CREMATORY Dor. Mem. Park	
23d. LOCATION CITY OR TOWN Cambridge		COUNTY Dor.		STATE Md.	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE MD.		ADDRESS CAMBRIDGE MD.		25a. DATE RECEIVED BY REGISTRAR FEB 02 1984	

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows in several lines]

John J. [Illegible]  
FEB 02 1964